STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205090	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Borderview Rehab & Living Ctr	208 State Street Van Buren, ME 04785

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on observations and interviews the facility failed to respond to resident call bell requests for assistance in a manner that maintained or enhanced their dignity for 3 of 12 residents (Resident [R] 18, R7, R13). Findings: 1. On 4/17/24 at 8:35 a.m., R18 stated that he/she feels there is not enough staff at times; this morning (during night shift), they turned off my call bell and didn't check to see what I needed and at times I may need my brief changed or my urinal emptied, and they just wait for day shift to do it. Another surveyor observed R18 call bell was activated to request assistance with his/her brief and noted the call bell was turned off from a location other than the resident's room. R18 used call bell again to state he/she still needed assistance, because no one had come yet. The resident used the call bell a third time to request assistance. On 4/17/24 art 8:40 a.m., during a follow up interview, R18 stated that yesterday sometime after lunch yesterday, family visited. R18 stated that he/she rang his call bell because he/she needed assistance after using the bathroom. R18 stated that he/she called numerous times, probably took an hour before someone finally came and helped him/her. 32540 2. On 4/16/24 at 11:44 a.m. during a resident interview R7 became very upset and stated, the call bell, I ring it and I have time to die twice over before they come in and they tell me they were busy, and it isn't my turn. Then stated, at one time I sat on the toilet for two hours before they came to help me. R7 stated that all they need is assistance to pull up their pants, but it takes so long. During this survey surveyors noted that the staff person who was at the desk would answer the call lights through their intercom system and turn off the call lights. They would ask the resident that was ringing what they needed and state ok, someone will be right with you. This action would turn off the call light, and when no one was right with you, the residents would have to call back then the person would page on the overhead speaker that the room and number (room [ROOM NUMBER]) needs assistance. On several occasions it was heard that the same room number kept calling for assistance. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Borderview Rehab & Living Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 208 State Street Van Buren, ME 04785	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 4/18/24 at 8:25 a.m. R13 used their call light to call for assistance, the call bell was heard at the nurses station. It was a double (fast) ring sound which indicated the call light was on for a few minutes. The nurse at the nurses station Registered Nurse [RN] 2 answered the call light via the intercom and told R13 be right there. This surveyor was observing call lights in the alcove nearest the front door, room [ROOM NUMBER] call light went on at 8:33 a.m. RN2 went into room [ROOM NUMBER], asked the resident if they were all done and turned off the call bell light. RN2 entered R13's room at 8:34 a.m. and asked him/her what they needed R13 stated they needed to use the bathroom. RN2 said, let me find your Certified Nursing Assistant [CNA] because they will want to wash you up at the same time and she left the room. At 8:46 a.m. R13 used their call bell light again RN2 paged overhead at 8:47 a.m. a CNA went in R13's room to assist with morning care and assisted to bathroom at 8:48 a.m., 23 minutes after first calling and notifying staff he/she needed to use the bathroom, each time the resident used the call bell and RN2 answered by using the intercom system the residents voice became more anxious (tone of voice was more urgent, they needed staff's assistance to use the bathroom). At 8:41 a.m. and again at 8:43 a.m., the overhead pager announced that room [ROOM NUMBER] needed assistance. The person answering the call bell light at the desk was answering via the intercom system turning off the residents call bell light and staff were not responding to the residents request for help timely causing the resident to use their call bell light again. On 4/18/24 at 12:49 p.m. another surveyor observed several call bell lights were on and ringing at the nurses station, this surveyor observed the call bell light for R13 was on and red in color (indicating the assistance was needed in the bathroom) the sound of the call light had been silenced and only the light was illuminated above the door. R13's room is in the front alcove near the front door and is not visible from other areas. At 12:51 p.m. R13's call bell light rang at nurses station and Licensed Practical Nurse [LPN] 2 answered via the intercom be right with you and silenced the call bell light, R13 was in the bathroom sitting on the toilet and needed assistance to get up and readjust his/her clothing and get back into their wheelchair. At 12:57 p. m. R13's call light began to ring at the nurses station and LPN2 answered the call bell light via the intercom and again stated, be right with you and turned off the sound of the call bell. At 1:00 p.m. LPN1 walked by R13's room and did not assist him/her. At 1:05 p.m.RN2 entered the room to assist R13. R13 sat on the toilet waiting for assistance for 16 minutes. On 4/18/24 at 2:15 p.m during an interview with the Assistant Administrator, two surveyors confirmed call lights were being turned off at the nurses station and that residents are having to call multiple times for assistance. A surveyor also confirmed an observation that R13 had waited for 23 minutes in the morning for assistance and 16 minutes in the afternoon for assistance to get off the toilet.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 32540 Based on review of Resident Council meeting minutes and interview, the facility failed to document results of the grievances voiced by members of the Resident Council for 3 of 3 months reviewed (January, February, March 2024). Finding: 1. In review of Resident Council meeting minutes from January 25, 2024, grievances were voiced regarding call bells taking a while to answer and reported to Director of Nursing Services (DNS) French toast were served cold for breakfast that morning and reported to Food Service Director. 2. In review of Resident Council meeting minutes from February 29, 2024, grievances were voiced regarding call bells take a long time to be answered and reported to Director of Nursing. 3. In review of Resident Council meeting minutes from March 28, 2024, grievances were voiced regarding call bells take a while to be answered this was passed to nursing, food was cold all week and this was reported to the Food Service Director who addressed this concern, and residents were informed on how this will be fixed (attached documentation showed they started to use steamtable for meal services). On 4/17/24 at 9:10 a.m., during an interview with the Assistant Administrator, she stated that the DNS was not aware that she had to respond to the Resident Council concerns, and the outcomes were not shared with the Residents. At this time, a surveyor confirmed the Resident Council meeting minutes lacked evidence that all the areas of concern were addressed by all departments, and the outcomes were not conveyed to the residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32540 Based on record reviews, and interview the facility failed to ensure that physician orders were followed for 1 of 5 residents reviewed for unnecessary medications. (Resident [R] 8). Finding: On 4/17/24 during a clinical record review, R8 had a written order dated 3/7/24 documenting 3/5/24 labs were reviewed CBC (complete blood count), CMP (comprehensive metabolic panel), iron, and Hgb (hemoglobin) of 7.6 results meets the transfusion criteria. The order directs that if family and resident is willing, to send R8 to the Emergency Department, and if not to please obtain occult blood stool ASAP (as soon as possible). And to repeat CBC today. There is no evidence in the clinical record electronic or paper records that the occult blood stool was completed as ordered. On 3/11/24 another order was written that 3/8/24 labs were reviewed, R8 declined the transfusion, and that R8 needs an occult blood stool ASAP as previously ordered. (previously ordered ASAP on 3/7/24) and to consider comfort care. On 4/17/24 at 2:45 p.m. during the clinical record review and during an interview with the charge nurse Licensed Practical Nurse [LPN] 1 there is no evidence that the ASAP occult blood stool sample was collected/completed. LPN1 reviewed the laboratory calendar book and R8's electronic Treatment Administration Record (TAR). There is no evidence that this order was completed as ordered. LPN1 called the lab to verify if this order was completed and per the laboratory this order was not completed as of this date 4/17/23, 41 days after the ASAP order was received from the provider to address the low hemoglobin results. During this interview the surveyor confirmed the above finding.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35904 Based on record review and interviews, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 5 of 62 days reviewed for RN coverage (October 2023 and December 2023). Finding: On 4/16/24, during a review of nursing working schedules from 10/1/23 - 12/3/23, they indicated that on 10/1/23 (Sunday), 10/8/23 (Sunday), 10/9/23 (Monday), 12/2/23 (Monday), and 12/3/23 (Sunday) the facility did not have a Registered Nurse (RN) on duty for at least 8 consecutive hours. On 4/16/24, at 2:17 p.m., in an interview with the Assistant Administrator, a surveyor confirmed the lack of RN coverage for at least 8 consecutive hours a day, 7 days a week on the dates identified in October of 2023 and December of 2023.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32540 Based on observation and interview the facility failed to ensure kitchen staff properly wore hair nets by leaving hair uncovered and unrestrained for 1 of 3 days of survey (4/17/24). Findings: On 4/17/24 at 7:00 a.m., during the breakfast meal service, a surveyor observed that the dietary aide serving breakfast from the steamtable did not have a beard restraint on while performing food service tasks. On 4/17/24 during an interview with the cook at 7:08 a.m., he stated that they were not aware that the beards had to be covered. At this time, it was observed that the cook had facial hair as well and was not covered. On 4/17/24 at 7:10 a.m. this surveyor observed a second dietary aide bring a hair net for the dietary aide serving breakfast to cover his facial hair. On 4/17/24 at 8:30 a.m. the surveyor confirmed with the Food Service Director that the dietary aide and the cook did not have a beard restraints on while performing food preparation and service tasks.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record reviews and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident [R] 7, and R16). Findings: On 4/17/24 at 1:34 p.m., during an interview with the Infection Preventionist (IP), she stated that per the facility pharmacist, and CDC guidance, if the resident received the PCV13 and PPSV23, they should receive the PCV20 five years after the last pneumococcal vaccine given. 1. R7's admitted to the facility was on 10/12/22. During review of immunization records, R7 received a PPSV23 on 12/6/17, and a PCV13 on 12/22/16. A surveyor could not locate evidence that R7 was reviewed, offered, or received a PCV20. The Resident is over [AGE] years of age. 2. R16's admitted to the facility was on 1/24/24. During review of immunization records, R16 received a PPSV23 on 2/29/11. A surveyor could not locate evidence that R16 was reviewed, offered, or received the PCV20. The Resident is over [AGE] years of age. On 4/17/24 at 1:34 p.m., during an interview with the IP, a surveyor confirmed that R7, and R16 were not offered, or received a PCV20, and should have been.